

Bethlehem Views Limited - Bethlehem Views

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bethlehem Views Limited
Premises audited:	Bethlehem Views
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 22 September 2016 End date: 23 September 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	86

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Bethlehem Views Limited provides rest home, hospital and secure dementia care in Tauranga.

The provider has announced a change of operator/control which is scheduled to take effect on 1 October 2016. The Ministry of Health advised this does not require a provisional audit. Otherwise there have been no changes to the organisation or the scope of services provided since the previous surveillance audit in April 2015.

This re-certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the Bay of Plenty District Health Board (BOPDHB). The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents and their families, management and staff. A general practitioner was interviewed on site and expressed confidence in the care and services provided.

This audit identified three areas of service delivery which required improvement and three areas where services exceeded the requirements. Improvements are required with the management of complaints, staff performance appraisals and safe restraint use. Communications, activities and management of short term medical and health interventions were rated as continuous improvements.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Families and residents interviewed expressed satisfaction with the caring manner and respect that staff show towards each resident.

There are no known barriers to residents accessing the service. Services are planned to respect the care required, culture, values and beliefs of all the residents, including Maori residents.

Written consents are obtained from the residents' families/whanau, enduring power of attorney (EPOA) or appointed guardians, when necessary. When signing consent forms there was an option for information to be provided in six different languages.

Residents are encouraged and supported to maintain strong community and family links.

The documented complaints management system meets the requirements of the Code. Families reported that staff immediately respond to and begin to address any concerns they raise. There have been no external investigations by the district health board or the Office of the Health and Disability Commissioner since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Residents and staff have been informed about the intended change of operator in the near future. The current director/operators continue to meet regularly with the general manager (GM) to monitor progress against the business/strategic plan and to be updated about operational matters. There has been a change of clinical nurse manager and team leader who report to the GM. The senior management team are appropriately qualified for their positions and have experience working in the aged care sector.

The quality and risk management systems are well established and meet the required standards. Staff are monitoring service delivery through internal auditing, analysis of quality data, benchmarking and by actively seeking feedback from residents and their families. There are effective systems for identifying and managing actual and potential risks.

Adverse events are being reliably reported, investigated and analysed to predict and minimise unwanted trends. The organisation has made essential notifications where required to the district health board and the Ministry of Health.

New staff have been recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff. Ongoing staff education is planned and co-ordinated to ensure that staff receive relevant and timely training on subjects related to their roles and service provision to older people. Training occurs at least monthly through in-service education sessions, and through self-directed learning and presentations by external experts.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of residents. The allocation of registered nurses (RNs) across the site meets contractual requirements.

Consumer information management systems meet the required standards. Archived records are stored securely and all resident information is integrated and readily identifiable using relevant and up to date information.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Pre-admission information clearly and accurately identifies the services offered in both enquiry and information packs provided to new residents. The service has policies and processes related to entry into the service.

Residents are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops a care plan specific to the resident. This is developed with the resident, family and existing community supports and health care professionals. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan, as needed. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have 'interRAI' assessments completed and individualised care plans.

Residents are reviewed by their GP on admission and assessed thereafter either monthly or three monthly depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Diversional therapists provide planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives. Residents are encouraged to maintain links with family and the community.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a four week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

A safe medicine administration system was observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are effective and safe processes for managing waste and hazardous materials. The building has a current warrant of fitness. Residents' bedrooms were spacious and personalised. Communal areas are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained.

Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There is regular monitoring and reporting on the effectiveness of cleaning and laundry services.

Emergency systems and the equipment needed for emergencies is being checked frequently. This includes the ability to provide sufficient food and water for the number of residents for at least three days. There is an approved evacuation scheme and systems for ensuring that all staff attend fire updates at least annually. All registered nurse and some auxiliary staff hold current first aid certificates. The facility is heated in ways that provides comfortable and constant internal temperatures. Electrical equipment is being checked annually. All medical equipment is serviced and calibrated annually. Hot water temperatures are monitored.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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On the days of audit the restraint register was up to date and contained sufficient detail about each resident who required interventions for safety. There were two restraints and six enablers in use on the days of audit. The Restraint Minimisation and Safe Practice Standard was met.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The facility has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents and their families. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at staff and management meetings.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	2	1	0	0
Criteria	3	95	0	1	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed throughout the facility on corridor walls in full view.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation with ongoing and updated training occurring at regular intervals. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents’ files reviewed had consent forms signed by the resident, family and/or enduring power of attorney (EPOA). Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in</p>

<p>informed choices and give informed consent.</p>		<p>their relative's care and decision. Advance directives are signed by the resident if competent. Staff interviewed acknowledged the resident's right to receive, refuse and withdraw consent for care/services.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>All residents receiving care within the facility have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate within the local community.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. Family/whanau interviews reported that residents are supported and encouraged to interact with community groups whom visit the facility and while residents are out visiting in the community. Evidence was documented in daily and planned activities in resident's progress notes and care planning, such as church services and interaction of different community groups.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The documented complaint management system complies with right 10 of the Code and the requirements of this standard. There had been no serious complaints received since the previous audit in April 2015. The residents and family members interviewed confirmed that they had been provided written and verbal information on how to make a complaint. The complaint procedure is clearly documented in the residential agreement.</p> <p>The sighted complaints register contains 13 complaints received since the 2015 surveillance audit. The complaints management process was not followed in dealing with four of these complaints and a complaint raised in the review of a residents care was not listed in the register. There is an improvement required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	<p>FA</p>	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the family on admission and is evidenced in the admissions agreement and information packs.</p>

rights.		The family/whanau that were interviewed reported that the Code was explained to them on admission. The Code of Rights and process was also regularly discussed at family meetings. Residents, family members and whanau expressed that they were happy with the care at the facility and provided by the staff.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The families/whanau interviewed reported that the staff are meeting the needs of their relatives.</p> <p>The families/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering.</p> <p>No concerns in relation to residents' abuse or neglect were mentioned. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The policy acknowledges the facility's responsibilities in accordance with the Treaty of Waitangi and/or other protocols/guidelines in meeting the needs of Maori residents. The facility is committed to identifying the needs of its resident's cultural and spiritual needs and ensuring that staff are trained and capable of supporting appropriately all residents in their care.</p> <p>The clinical nurse manager reported that there are no barriers to Maori accessing the service. At the time of the audit there was one Maori resident. The health care assistants and registered nurses interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture. This was also evidenced in care plans expressing the resident's specific and individual needs in relation to their Maori culture and beliefs. The relative/whanau interviewed confirmed that they were happy with the cultural and spiritual support that was provided for their relative.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	FA	<p>Staff liaise with family/whanau at the time of admission and at regular intervals to ensure cultural or religious visits continue as appropriate. Residents have access and are supported to attend services within the facility and in the community.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families interviewed were happy</p>

respect their ethnic, cultural, spiritual values, and beliefs.		with the care provided by those staff who also identify with a different culture.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Families/whanau reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries and attend regular training.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice was observed and evidenced in interviews with the registered nurses, health care assistants and in the care planning process. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GPs, links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines/policy are utilised as appropriate.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The families/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover including any DHB and/or external consultant specialist appointments. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all residents spoke English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bethlehem Views can accommodate 91 residents and on the days of audit there were 86 residents. This comprised 45 residents requiring rest home level care, 21 requiring hospital level care and 20 in the secure dementia wing. There were no residents under the age of 65 years. One resident is funded under a Ministry of Health contract. The organisation has a clearly defined scope, direction and goals documented in the 2015-2016 business plan. The GM provides regular verbal and written reports to the directors on service delivery outcomes, quality improvement projects, financial issues, compliments, complaints, audit outcomes and staffing information. The GM who has been in the role for six years, oversees the day-to-day service delivery

		and operations for Bethlehem views from another facility in Hamilton and is onsite at Bethlehem Views one to two days a week. This person is a NZ Registered Nurse with many years clinical and managerial experience working in physical rehabilitation, elderly, dementia and palliative care facilities. The GM is maintaining a nursing portfolio by attending ongoing, relevant education in nursing, leadership and management. The clinical nurse manager who was employed in 2015 is a registered nurse with palliative clinical experience in age care. Review of personnel files and interviews confirmed that all senior management staff are qualified for their roles and maintain their skills and knowledge by attending regular professional development and industry conferences.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	Discussions with the GM and clinical nurse manager and other staff confirmed that cover for planned absences is delegated to the next most suitable and senior person. Staff stated these arrangements were proven to be effective and ensured continuity for staff, residents and their families.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Review of documents and interview with the quality coordinator showed that the organisation is maintaining effective quality and risk management systems. Policies are reviewed against current standards, legislation and known best practice two yearly, or earlier when required. The policies include reference to the requirements for interRAI assessments and care planning.</p> <p>All quality data, such as incidents/accidents, infections, pressure injuries, results of internal audits, complaints and service delivery improvements continues to be analysed and discussed with all levels of staff at weekly and monthly meetings. There is evidence of actions being implemented to good effect when service deficits are identified.</p> <p>Residents and family members interviewed confirmed they are consulted about services and are being kept informed.</p> <p>The organisation's annual quality plan, business plan and associated emergency plans identify current actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. Environmental risks continue to be communicated to visitors, staff and residents as required. Review of a range of meeting minutes showed that health and safety, including new hazards and resident related risks, are discussed. Trial fire evacuations have occurred every six months.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There are established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. The reporting system is overseen by the quality coordinator and was known by the staff who were interviewed. The event records reviewed on the days of the audit showed that internal reporting and external notification occurs immediately or as soon as practicable. Staff, families and others who are impacted by an adverse event (for example, GPs or the district health board) are informed in a timely manner. Each preventable event is investigated to determine cause and prevent or minimise recurrence. Observation on the days of audit confirmed that incidents are discussed at shift handover, and trending data is displayed. Each resident's file contained incident reports which facilitated a ready review of risks.</p> <p>The GM is responsible for essential notification and reporting and understands the statutory and regulatory obligations. There has been notification of a pressure injury in 2015 to the DHB and MoH.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Recruitment for new staff adheres to best known employment processes. Each of the 14 staff files reviewed on site contained evidence of formal interviews, verification of qualifications, copies of notes from referees who had been contacted and police checks completed before confirming an employment agreement. The personnel records also showed that the registered nurses and enrolled nurses have current practising certificates, and that each role has a job description. All staff are employed on individual employment agreement which includes a trial 90-day period.</p> <p>The orientation programme covers organisational systems, quality and risk, the Code of Health and Disability Services Consumers' Rights (the Code), health and safety, resident care, privacy and confidentiality, restraint, infection prevention and control and emergency situations. One new clinical staff person interviewed said the orientation process worked well for them. There is an improvement required about the frequency of staff performance appraisals.</p> <p>Clinical staff attend compulsory training in emergency management, first aid, medicine administration, manual handling and infection control. The service supports all staff to engage in ongoing training and education related to care of older people.</p> <p>The service supports health care assistants to complete specific education in aged care. The sample of personnel files from staff rostered to work in the secure unit showed all had either completed or were working to achieve the required unit standards in dementia care. The records showed that 90% of RNs, enrolled nurses (ENs) and the activities staff are maintaining certificates in first aid. Rosters revealed there is always an RN with first aid on site. All staff who require competency in medicines administration are being assessed at least annually.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Bethlehem Views has a clearly documented and implemented staffing rationale. Rosters sighted and interview with different levels of staff confirmed there are the required numbers of skilled and experienced staff on all shifts in each service area. This complies with the provider's agreement with the district health board (ARC contract). Staffing allocation takes into account the acuity and support needs of residents. The service is maintaining ratios of one staff member to four residents in the memory loss unit, plus a registered nurse and one staff member to five residents in the rest home and hospital. An additional (fourth) RN has been rostered on each Saturday and Sunday as backup for administrative and clinical workloads. Staff stated there are enough staff on each shift and effective backup systems are in place to cover staff absences. There were no concerns expressed about staff turnover. Residents and their relatives were satisfied with the skills, experience and availability of staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Clinical notes were current and integrated with GP and auxiliary notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed. No personal or private resident information was observed to be on public display during the days of audit.</p> <p>Archived records were being safely held on site for 10 years.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The facility has an admission/enquiry form that records pre-admission information. When an enquiry is made, it is then entered into a database which holds record of the enquiry and is regularly followed up by the facility. The resident admission agreement is based on the Aged Care Association agreement which is individualised to the service. The resident's records reviewed have signed admission agreements by the resident/family or EPOA.</p> <p>The entry criteria were sighted and the services website clearly identifies what services are provided. Vacancies are updated daily through Eldernet and Bethlehem Views has their own web site. Staff after hours and on weekends are able to support potential new residents/families' enquiries.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The facility uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, process when and error occurs as well as definitions for 'over the counter' medications that may be required by residents. The sighted policies meet the legislative requirements and best practice guidelines.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of the audit. Medicines were stored in a locked medicine trolley and stored in a locked room.</p> <p>The facility has implemented an electronic medication charting and management system. The 36 medicine charts sighted have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident. One resident self-administers medications and documentation and assessment of the resident's ability was evidenced and was reviewed every three months by the registered nurse and GP. The resident's medication is in a secure location in the resident's room.</p> <p>There are documented competencies sighted for the staff (registered nurse and health care assistants) designated as responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management. The medicine competencies undertaken by current staff include specific insulin and warfarin instructions.</p> <p>Current medications that require to be refrigerated are correctly stored and the registered nurse is responsible for the recording of temperatures. All temperatures were maintained within the recommended range.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a four week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry, a copy of the nutritional profile is provided to the kitchen staff to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen manager sees each resident at least monthly, to receive feedback on the meals and update any special requirements or requests. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>The kitchen offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner. All main meals are supported by morning and afternoon tea which includes home baking. An alternative meal is offered if preferred by the resident. There is a small kitchenette situated in the special care memory unit where residents are supervised and supported to prepare and cook food and the making of hot/cold beverages.</p> <p>All meals are cooked and served directly from the kitchen and served in the dining rooms. Residents have breakfast in their rooms and are encouraged to have their lunch and evening meals in the dining rooms to encourage appetites and socialisation.</p> <p>The residents and family/whanau interviewed reported satisfaction with the meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The clinical nurse manager interviewed reported that the facility does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The facility has implemented the electronic interRAI assessment. Specific assessment tools for all residents remain paper based. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and includes falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from their prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure injury risk assessments.</p> <p>The family/whanau interviewed reported their relative receives 'above and beyond the care required' to meet their relative's needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The 18 residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in interventions and evaluations of residents' files. The health care assistants interviewed demonstrated knowledge about the individual resident's they care for.</p> <p>The residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the senior registered nurse, care and activity staff and medical and allied health services. The registered nurse and healthcare assistants interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to</p>	<p>FA</p>	<p>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the days of the audit, the registered nurses and healthcare assistants demonstrated good knowledge of individual residents. Staff were observed to redirect and distract residents with</p>

<p>meet their assessed needs and desired outcomes.</p>		<p>challenging behaviour providing individual and specific care that as reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The family/whanau interviewed reported that the staff knew their resident very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and health care assistants interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme uses a framework to empower the residents to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing of new interests. The activities coordinator adapts activities to meet the needs and preference of choices of the residents.</p> <p>A diversional therapist works in the special memory loss unit Monday to Friday (40-hour week). The weekly activities plan sighted is developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The residents have the opportunity and are also encouraged to partake in daily activities of living, for example, household chores, cooking, going to the movies, visiting the shopping centre and having coffee.</p> <p>The rest home/hospital diversional therapist works Monday to Friday (40-hour week) and is supported by an assistant (35-hour week) ensuring that residents are supported six days a week. Regular activities include daily newspaper reading and exercises, church services. Public holidays, special events and monthly themes are celebrated. Different community group's visit and residents are encouraged to attend events and activities within the community. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The health care assistants interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff promote social interaction by inviting and encouraging all residents to join in activities together in the main lounge.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p>

		<p>A challenging behaviour and assessment tool and monitoring form is developed for residents and care plans sighted evidenced interventions to support residents whom are presenting with challenging behaviours over a 24-hour period.</p> <p>Letters of appreciation by families were evidenced. All families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or are not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans were sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans were documented in the residents' progress notes. The healthcare assistants interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There is one GP who visits the residents at the facility and is available after hours via phone. The RN in discussion with the GP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that appropriate referrals to other health and disability services are well managed from the facility.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	FA	<p>There are clearly described policies and procedures for the safe and appropriate disposal of waste, and infectious or hazardous substances. These comply with local government and legislative requirements, the requirements of this standard and the provider's aged residential care contract.</p> <p>Visual inspection and interviews with care staff, cleaning and laundry staff on the days of audit, revealed</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>that chemicals were stored securely and that there is safe disposal of body waste and contaminated or potentially infectious products. Incontinence products are doubled bagged and bins are emptied to outside containers regularly. The sluice rooms were clean and well equipped. Personal protective equipment is available and staff were observed using this on the days of audit.</p> <p>Staff training records and interviews confirmed that all staff are provided with initial education on the safe handling of chemicals. Ongoing education and support with this is provided by the chemical supplier.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building of warrant of fitness (BWOFF) is current and due to expire on 11 April 2017.</p> <p>Visual inspection of all internal and external areas revealed no environmental hazards. Interview with staff and members of the health and safety team confirmed vigilance in identifying, reporting and removing any potential risks to residents, staff or visitor safety. Hazard monitoring and preventative maintenance is ongoing.</p> <p>Interview with the GM, quality person, maintenance person, review of records and observations on the days of audit showed that electrical testing and tagging is completed annually by a certified electrician and calibrations of scales and medical equipment occurs as required by the device. Inspection of the equipment revealed that fire safety equipment and hoists are regularly checked for safety. The service vehicle had a current warrant of fitness and registration</p> <p>External furniture and walkways were viewed as safe for use by the resident group and are being well maintained. There is ready access to outside sitting areas with protection from the elements. Residents and relatives interviewed were highly satisfied with the surroundings.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Each bedroom has an individual toilet and shower ensuite and in many instances staff are supporting residents with showering. There is an additional room with bed shower in the hospital/rest home wings and additional staff and visitor toilets are conveniently located throughout the building. There have been no reported issues with maintaining resident's privacy when attending to personal hygiene needs.</p> <p>Hot water monitoring is occurring monthly and temperatures are well within safe limits of below 45 degrees. The temperature of all hot water outlets is moderated by tempering valves. This was confirmed by hand testing of taps in various locations during the onsite audit. Hand washing facilities and gel sterilizer units are located throughout the facility for staff and visitor use. Residents and families interviewed were very happy with the facilities provided.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Visual inspection on the days of audit revealed one bedroom was occupied by a married couple otherwise all rooms were occupied by one person. Each bedroom was spacious and easily accommodated a bed, occasional furniture, easy chair and personal effects. There is enough room for residents to move around safely with or without a mobility aid and double entry doors allow easy access to each bedroom. Residents and their families expressed satisfaction with their personal space. The service meets the requirement of the ARC contract and this standard.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are now two open dining areas for rest home and hospital residents. These are furnished with sufficient tables and chairs of a height and design suitable for older people. The size of the main lounge area with access to external decks and gardens was considerably extended to accommodate the increase in resident numbers in 2014. These areas are well lit by large windows and external doors and are used for activities during the day. A second lounge in another wing is also used for activities, meetings, visiting and church services. Residents were observed to be accessing the recreational and dining areas by themselves or with support from staff. There is plenty of other internal and external seating areas. The secure unit has a large communal lounge and dining area and smaller areas for activities and visiting.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The reviewed policies and procedure clearly describe safe and effective methods for the provision of hygienic laundry and cleaning services. Interview with laundry and cleaning staff and residents and families revealed no concerns. The laundry easily accommodates two industrial washing machines, one industrial drier, smaller washing machines, ironing and clothing storage space. Laundry and cleaning staff are rostered on site seven days a week. Personnel records and staff interviews confirm appropriate orientation to job role and duties and attendance at ongoing training in safe chemical use. Material safety data sheets for each product are available where the chemicals are located. Chemical dispensing stations and trolleys are stored securely in locked rooms. Visual inspection revealed these are clean and well organised.</p> <p>Systems, such as audits and resident and family surveys, monitor the effectiveness of the laundry and cleaning services provided. Monthly visits from the chemical supplier includes testing the effectiveness and safe use of cleaning and laundry products.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	<p>FA</p>	<p>Bethlehem Views has clearly described emergency plans. Interviews with all levels of staff demonstrated that emergency and security systems are known and understood. The building has an approved fire evacuation scheme. Records showed that fire drills are occurring every six months. Staff</p>

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>attendance at these is monitored to ensure everyone attends at least one fire safety update annually. There was evidence in the staff files sampled that information and testing of knowledge about emergency procedures occurs during orientation. There are sufficient numbers of registered nurses on site and on call twenty-four hours a day, seven days a week for the management of emergencies.</p> <p>Interview with staff and inspection of the emergency/civil defence stores confirmed there was sufficient stock of food, equipment and essential supplies in the event of a natural disaster or power outage. There is 25,000 litres of water on site, and the facility has back up lighting but no generator. Residents requiring oxygen would have this supplied by portable oxygen bottles. The call bell system was observed to be functional during the onsite audit. Residents and families interviewed confirmed that staff usually respond to call bells in a timely way.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Each rest home/hospital bedroom has a heat pump with air conditioning option so residents are able to adjust individual room temperatures. Temperatures in communal areas and in the secure until are moderated by staff. Each bedroom has at least one opening window and in the hospital/rest home, external opening glass doors that provide adequate ventilation. Residents and families were satisfied with lighting, heating and air flow in all areas of the facility.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>A RN is the infection control coordinator and is responsible for following the programme as defined in the infection control manual. Infections are monitored by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at staff meetings. If there is an infectious outbreak this is reported to staff, management and where required, to the DHB and public health departments.</p> <p>The RN reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover and in resident's documented short term care plans and progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from</p>

		infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The clinical team leader has the role of infection prevention and control coordinator. Infection control issues are identified to staff. The facility has the support of a clinical infection control specialist doctor and clinical nurse specialist who is available for advice on infection prevention. Advice can also be sought from different external sources, including the laboratory diagnostic services and the GP. The infection control coordinator regularly attends infection control education. The registered nurse and health care assistants interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including managing sharps, managing multi-drug resistant organisms, exposure of blood and body fluids, personal protective equipment, single use items, outbreak management and pandemic policy, cleaning disinfecting and sterilisation, waste management policies, and policy related to staff sickness/infections. Staff were observed at the time of audit demonstrating safe and appropriate infection prevention and control practices.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The registered nurses and health care assistants interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the registered nurse. Infection control is integrated within the new employee induction manual and in-service education sessions are held for staff. Family/visitor education is provided where appropriate.

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors urinary tract infections, respiratory tract infections, fungal skin, soft tissue, scabies, and eye and gastroenteritis infections. Antibiotic use is also closely monitored as discussed with the GP and reviewed in clinical records. The monthly analysis of the infections includes trends and actions taken to reduce infections. This information is fed back and discussed in staff, and where appropriate, at resident meetings.</p> <p>Infection rates for respiratory infections for April 2016 was seven, and in June was reduced to two. In August of 2016 urinary tract infections increased to seven; four residents were identified as having a chronic medical history and frequent infections. One resident has since deceased. Care planning and intervention/evaluation and minutes of meetings showed how staff were reducing and minimising risk and trends and actions to take to reduce the spread of infections for individual residents and as a facility. All residents who were unwell were assessed as being at the appropriate level of care. Families/whanau interviewed reported that they were made aware, within appropriate timeframes, of their relative being unwell and the interventions/actions in place.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy and procedures are from a consultant's standardized quality system and the service has not substantially modified these. The policy definitions are congruent with this standard and state the approved restraints are lap belts and bedrails. Completion of the forms for assessment, consent, review and monitoring and quality management review is occurring. The service is actively trying to reduce the amount of restraint in use by using more low beds and fall out mattress protectors. These were observed to be in use in at least four bedrooms.</p> <p>On the days of audit the restraint register listed two residents with restraints, one with a bed rail and one with a lap belt. Six residents are using bedrails as enablers (two of these additionally use safety belts when in wheelchairs). Discussions with the restraint coordinator and review of residents' records and restraint documentation revealed that assessment and consent had been obtained and that monitoring and quality evaluation and review of all restraints and enablers is occurring. Further evidence was obtained from interview with a resident using an enabler and close observation of the use of a three-way lap belt with one resident and interview with their family member.</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	<p>FA</p>	<p>There was documented approval for use of both restraints and all enablers in the restraint register reviewed. Families are included in discussion and are provided with information about restraint and</p>

<p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>enablers which clearly identify the risks associated with these. Two family members interviewed confirmed this had occurred and they had also reviewed the plan of care for their parent.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The two resident's records reviewed of residents using restraints contained a comprehensive account of the assessment made prior to use. These included current falls risk, a history of incidents, alternatives tried and reasons for the assessment being conducted. All risks associated with the bed rail or lap belt were identified and highlighted.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Low</p>	<p>The alternatives considered and trialled before initiating restraint were documented in the assessment forms and in the care plans. The quality person, RNs and the restraint coordinator educate and support staff to try alternatives. All staff must attend annual restraint training which includes a competency test. The restraint register records the type of restraint in use, the frequency of monitoring and review and the date it was initiated. Staff were not following the care and monitoring requirements for the use of one restraint, an improvement is required.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Documents, including care records, and staff interviews confirmed that ongoing restraint use is routinely evaluated and reviewed at least six monthly by the RNs and restraint coordinator. The records, staff interviews and observations revealed the service is trying different approaches to prevent harm from falls and reduce restraint use (for example, low beds, fall out mattresses and more use of sensor mats). The restraint coordinator maintains ongoing communication with families and supports and encourages staff to trial new methods for keeping clients safe without the use of bedrails or lap belts. The records of the resident reviewed in detail, an appropriate increase in the frequency of evaluations. The time interval was reduced from six months to four months (13 April to 30 August). Although the provider meets the requirements of this standard the improvement required in criterion 2.2.3.4 suggests that a further or even more frequent assessment and evaluation of the care provided to this resident is indicated.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Interview with staff and management and review of meeting minutes revealed that an annual quality review of restraint use and practices occurred in December 2015. The review revealed a downward trend in restraint use from the previous year due to the purchase and use of more low-low beds and sensor mats. The minutes showed there had been no adverse events. Audits revealed no non-compliances at the time, no change to policy and procedures and that staff education and restraint competency assessments for care staff was occurring. The provider meets the intent of this standard.</p>
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	<p>PA</p> <p>Moderate</p>	<p>Review of the complaints register, the documentation about each matter, staff and family interviews reveal that the correct procedures for managing complaints are not being adhered to. There was a lack of detail in the register. The information on some matters only contained a staff account of the issues and no other evidence of what complainants had been told or when and how resolution has been achieved. The file of one resident reviewed in detail and interview with their family member, revealed dissatisfaction about some aspects of</p>	<p>Not all complaints are listed in the register. The documented process has not been followed in four of the thirteen complaints on record. For example, a letter of acknowledgement, the offer of advocacy, explanation about the investigation and the processes to follow, how the complainant will be kept informed and there is no date or evidence that matters have been resolved.</p>	<p>Ensure that all concerns and complaints are managed according to the documented policy and process.</p> <p>90 days</p>

		care and loss of belongings, yet there was no information in the complaints register or records about how or whether these matters had been addressed.		
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Five of the 14 staff files reviewed either contained no record of a performance appraisal or revealed long gaps between performance appraisals. This was further confirmed by the electronic database which showed eight of the 17 employed RNs were overdue an appraisal. Two of the seven clinical staff interviewed said that performance appraisals were not regular.	Performance appraisals are not occurring regularly and/or at least annually for all staff.	<p>Strengthen and develop the systems for ensuring that all staff engage in an annual performance appraisal.</p> <p>180 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p>	PA Moderate	Interview with a family member, review of one resident's file in detail, observations of the resident and review of the restraint monitoring records reveals that the instructions to mobilize four times a day were not being followed. Staff were checking the restraint hourly but not attempting to move or reposition the resident while the restraint is in place. The amount of time staff spend mobilising the resident had been an ongoing issue for the family for five months. These instructions and additional reporting were initiated three weeks earlier yet adherence to the instructions had not been considered until the days of the audit. Observations showed the	The care requests and monitoring of the restraint in place for one resident is not being sufficiently understood and/or complied with. A documented evaluation on 30 August, of one resident reviewed in detail, showed that the restraint coordinator had another discussion with the family who said they did not want the device removed and wanted evidence the resident was being regularly walked. The most recent care instructions (to mobilise twice every morning and afternoon shift) and new recording procedures were initiated three weeks earlier. Observations on the days of audit and the records show staff were not complying with this. The	Review the plan of care in relation to restraint use in accordance with the family's wishes and the current condition of the resident. Ensure all staff understand and follow instructions for

<p>(f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>		<p>resident in the same sitting position for more than four hours and the records revealed the lap belt was in place for up to six hours at a time.</p>	<p>monitoring requirements and record of observation for the other restraint in use meet the requirements.</p>	<p>mobilisation and/or other positional movement.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	CI	In the memory loss unit it was identified thru staff observations and interactions that the majority of families/whanau supporting their relatives in a new and different environment, such as the memory loss unit were struggling with different emotions and this was affecting the building of therapeutic relationships between staff and family/whanau and ongoing relationships between family/whanau and their relatives. As a result, a family support meeting was established. The first meeting had 17 of the 20 families attending. The meetings now occur on alternative months and is facilitated by the unit but led by the families/whanau. Meeting minutes and thank-you letters from relatives/whanau show topics discussed, such as different families' journeys, emotions, and feelings of guilt, the chance to ask questions and have them answered not only by the staff but by other family members when appropriate. Guest speakers have also attended and spoken about topics that were important to the families/whanau. The meetings also give the staff the opportunity to discuss with families, activities that they may like to participate in or facilitate. Thank-you letters evidenced appreciation of staff and more awareness of how the unit works and its concepts around supporting their residents. Interviews with families/whanau at the time of audit reported that they are very appreciative of these meetings and the opportunity to talk and share their experiences and the chance to learn from others. Staff have observed that family members/whanau appear more relaxed when	The service is rated a continuous improvement by demonstrating positive outcomes for residents and their relatives in developing and facilitating ongoing family support meetings.

		they visit and are more open with communication.	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	CI	<p>Due to the introduction of short term care plans in September 2015 and the change in the capturing of information around infections/antibiotic use, wound documentation and other short term interventions to support clinical care it was noted by the clinical management team that staff were confused in relation to the required documentation. Education was provided to the registered staff. A register was developed to support staff in closing and signing of short term care plans once presenting condition/situation was resolved. In June further training was provided in the form of tool box sessions as it was identified in staff meetings that staff were still unsure about the process of completing short term care plans, complicated by changes in senior staff and redistribution of roles. An audit was completed in August 2016 to review the compliance of documentation with short term care plans (the focus on antibiotics) the result was 83%. With further tool box sessions another audit was planned and completed in September 2016, the result was 100%. Regular oversight is ongoing with planned audits for the future.</p>	<p>The implementation of initial and now ongoing training to ensure that short term care plans/documentation are understood and completed in full has resulted in full compliance, supporting clinical care and ensuring the residents receive their antibiotics as prescribed thus a desired outcome.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Breakfast is normally served for residents in their rooms. A small group of ladies/residents whom present with a cognitive impairment whom staff observed and documented would become anxious due to forgetting that they had had breakfast were encouraged to have breakfast in the dining room. These residents are encouraged to make their own breakfast with supervision and support from staff in the small kitchenette in the main lounge. This activity creates normality for the residents as individuals and as a group also allowing for socialisation. Staff have observed and documented in the residents notes and evidenced as saying that resident was in 'good spirits' was 'more settled' having been to breakfast club.</p>	<p>The service is rated a continuous improvement for the way the breakfast club has lowered anxiety in residents with cognitive impairment. Residents are more settled during the day. Staff are reporting that the residents are less anxious and less repetitive in asking questions around</p>

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End of the report.